TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
ERIC A. VANDERWERFF, DC

Respondent Name
CALIFORNIA INSURANCE COMPANY

MFDR Tracking Number
M4-17-2664-01

Carrier's Austin Representative
Box Number 06

MFDR Date Received
MAY 9, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…we are exempt from the limitation of 3 FCEs per compensable injury, because these FCEs that we are REQUIRED to perform, as per the ODG (which is required by the DWC's Rules), are exempted by §134.204."

Amount in Dispute: $1,337.44

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Requestor mischaracterized both the facts and law, and he is not entitled to any additional reimbursement. The request for medical fee dispute resolution fails to state that an additional FCE was conducted by Requestor before the dates of service at issue. The initial FCE took place on 02/22/16. Requestor billed $655.32 and was paid $639.24 for 12 15-minute units, or 3 hours, of FCE on 02/22/16. The bill and EOB for all FCEs performed in this claim, including the 02/22/16 date of service, are attached to this response as Exhibit A…The first FCE took place on 02/22/16. The second FCE took place on 03/16/16, and the third FCE took place on 04/11/16. Requestor billed for each of these dates of service, and Respondent paid Requestor pursuant to the allowed by the Workers' Compensation Fee Schedule…Because three FCEs had already been performed, Requestor is not entitled to any reimbursement for the fourth FCE performed on 05/23/16."

Response Submitted By: Stone Loughlin Swanson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 16, 2016	CPT Code 97750-FC(X12) Functional Capacity Evaluation	$229.16	Not eligible for review
April 11, 2016	CPT Code 97750-FC(X16) Functional Capacity Evaluation	$234.52	Not eligible for review
October 6, 2016	CPT Code 97750-FC(X16) Functional Capacity Evaluation	$873.76	$0.00
TOTAL		$1,337.44	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 and §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 150-PT time parameters or fee schedule allowance exceeded.
   - P12-Workers compensation jurisdictional fee schedule adjustment.
   - 119-Benefit maximum for this time period or occurrence has been reached.

Issues

1. Did the requestor waive the right to medical fee dispute resolution for FCEs rendered on March 16 and April 11, 2016?
2. Is the requestor exempt from the FCE limits outlined in 28 Texas Administrative Code §134.204(g)?
3. Is the requestor entitled to reimbursement for the functional capacity evaluation rendered on May 23, 2016?

Findings

1. 28 Texas Administrative Code §133.307(c)(1) states: "Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section. (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The dates of service in dispute are March 16, 2016 through May 23, 2016. The request for medical dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) section on May 9, 2017. This date is later than one year after the date(s) of service in dispute, March 16 and April 11, 2016. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307(c)(1)(B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution for dates of service March 16 and April 11, 2016.

2. Based upon the submitted explanation of benefits, the respondent denied reimbursement for code 97750-FC based upon reason codes "150-PT time parameters or fee schedule allowance exceeded," P12-Workers compensation jurisdictional fee schedule adjustment," and "119-Benefit maximum for this time period or occurrence has been reached."

   On the disputed date of service, the requestor billed CPT code 97750-FC.

   The American Medical Association (AMA) Current Procedural Terminology (CPT) defines CPT code 97750 as "Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes."

   The requestor appended modifier "FC" to code 97750. 28 Texas Administrative Code §134.204(n)(3) states, "The following Division Modifiers shall be used by HCPs billing professional medical services for correct coding, reporting, billing, and reimbursement of the procedure codes. (3) FC, Functional Capacity-This modifier shall be added to CPT Code 97750 when a functional capacity evaluation is performed."

   28 Texas Administrative Code §134.204(g) states, "The following applies to Functional Capacity Evaluations (FCEs). A maximum of three FCEs for each compensable injury shall be billed and reimbursed. FCEs ordered by the Division shall not count toward the three FCEs allowed for each compensable injury. FCEs shall be billed using CPT Code 97750 with modifier "FC." FCEs shall be reimbursed in accordance with §134.203(c)(1) of this title. Reimbursement shall be for up to a maximum of four hours for the initial test or for a Division ordered test; a maximum of two hours for an interim test; and, a maximum of three hours for the discharge test, unless it is the initial test. Documentation is required."

   The requestor states in the position summary that "we are exempt from the limitation of 3 FCEs per compensable injury, because these FCEs that we are REQUIRED to perform, as per the ODG (which is required by the DWC's Rules), are exempted by §134.204."

   The ODG guidelines that the requestor refers to in the position are addressed in 28 Texas Administrative

Code §137.100. Review of the documentation submitted finds that the requestor failed to provide the portions of the ODG that related to FCEs to support its assertion that the service in dispute would be "required" by the ODG. The Division concludes that the requestor's assertion regarding alleged requirement for FCEs is not supported. In addition, the requestor has not shown compliance with any applicable requirements in 28 Texas Administrative Code §137.100(f). For these reasons, 28 Texas Administrative Code §134.204(g) applies to the disputed service.

3. The respondent wrote, "The first FCE took place on 02/22/16. The second FCE took place on 03/16/16, and the third FCE took place on 04/11/16. Requestor billed for each of these dates of service, and Respondent paid Requestor pursuant to the allowed by the Workers' Compensation Fee Schedule…Because three FCEs had already been performed, Requestor is not entitled to any reimbursement for the fourth FCE performed on 05/23/16." The FCE in dispute is the fourth for the injury. The Division finds that the requestor exceeded the maximum of three FCEs for each compensable injury that may be billed and reimbursed pursuant to 28 Texas Administrative Code §134.204(g). As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	6/22/2017 Date

YOUR RIGHT TO APPEAL

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Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.